IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 10, 2007

Patti Davis, Administrator
Ashley Manor Care Centers Inc - Orchard
PO Box 1176
Meridian, ID 83642

License #: C-646

Dear Ms. Davis:

On October 18, 2007, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Orchard. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

This office is accepting your submitted plan of correction.

Should you have questions, please contact Rachel Corey, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

RACHEL COREY, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RC/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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November 16, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0759

Kathi Brink, Administrator
Ashley Manor Care Centers Inc - Orchard
PO Box 1176
Meridian, ID 83642

Dear Ms. Brink:

Based on the complaint investigation survey conducted by our staff at Ashley Manor Care Centers Inc - Orchard on **October 18, 2007,** we have determined that the facility failed to protect residents from abuse. Based on record review and interview, it was determined that the facility did not implement their policy and procedure on abuse after an allegation was made known. As a result, residents' rights to safety was not protected. This had the potential to result in danger to all of the residents in the facility.

This core issue deficiency substantially limits the capacity of Ashley Manor Care Centers Inc - Orchard to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **December 2, 2007. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **November 29, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**November 29, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **November 29, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **November 18, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Ashley Manor Care Centers Inc - Orchard.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/sc

Enclosure

c: Lynne Denne, Program Manager, Regional Medicaid Services, Region IV - DHW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R646	A. BUILDING _____ B. WING _____	C 10/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MANOR CARE CENTERS INC - ORCH	2150 S ORCHARD BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments A follow-up survey was conducted and the core deficiencies were found to be in compliance. However, a complaint investigation was also conducted and the following core issue was cited. The surveyors conducting your survey were: Rachel Corey, RN Team Coordinator Health Facility Surveyor Debbie Sholley, LSW Health Facility Surveyor	R 000	**R006** **16.03.22.510** **Protect Residents from Abuse** In regard to this citation Ashley Manor ascertains that the policy was followed by going through the steps of investigation to determine there was no abuse, however it was not written or reported to the agencies as was necessary. We would never ignore an allegation of abuse toward one of our residents and we didn't in this situation. In order to comply with the steps of our policy and the state rule, we have:	
R 006	16.03.22.510 Protect Residents from Abuse. The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse. This Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility did not implement their policy and procedure on abuse, after an allegation was made known. As a result, residents' right to safety was not protected. This had the potential to result in danger to all of the residents at the facility. On 10/17/07 at 11 a.m., a former employee of the facility reported she had witnessed physical and mental abuse between an identified resident and the house manager. She stated she was the only one who witnessed the abuse. She further described speaking with the Regional Manager about a week after the incident occurred. The Regional Manager was reported to have "done nothing" about the report.	R 006	***What corrective action was accomplished for those specific residents found to have been affected by the deficient practice?*** None of the residents were affected by this practice. However, to keep the residents from being affected, an in-service was conducted by the Administrator with the manager and Regional Director. The staff received inservice and an example form was filled out to show how the procedure would work (see copy) ***How will other residents be identified that may be affected by the same deficient practice?*** None of the residents were affected by this practice. However, to keep the residents from being affected, an in-service was conducted by the Administrator with the old manager and Regional Director. The new manager of this facility has also been orientated to the Abuse policy and the procedure to be followed.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathi Brink — TITLE: Administrator — (X6) DATE: 11/29/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R646	A. BUILDING _____ B. WING _____	C 10/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MANOR CARE CENTERS INC - ORCH	2150 S ORCHARD BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 006	Continued From page 1 On 10/17/07 at 3:31 p.m., the Regional Manager acknowledged a former employee reported an allegation of abuse. Additionally, she confirmed she did not follow the facility policy and procedures regarding abuse nor protect the residents from the potential of further abuse. The Policy and Procedure of the facility documented, "Immediately report the incident to your supervisor and regional director. The supervisor or Regional director will call the Area Commission on Aging....The Regional Director will do an investigation into the incident. In the event the suspected abuse involves an employee, they will be suspend pending the completion of the investigation." The facility's policies and procedures on abuse were not implemented to assure all residents were free from abuse. While the allegation of abuse could not be substantiated, it was determined that a break down in the facility's systems had occurred because appropriate steps were not taken after the allegation of abuse was made known. This break down had the potential to affect 100 % of the residents and had the potential to result in harm.	R 006	***What measures will be put into place or what changes will be made to ensure the deficient practice does not recur?*** An in-service was given to all of the Ashley Manor managers and Administrators and Regional Directors, which outlined the policy and how it is to be followed. When a new manager or Regional Director is hired they will receive in-service from the Director of Operations prior to beginning work to instruct them not only on the policy but on the procedure that must be followed. (See sample report and documentation of in service for managers and employees) ***How will the corrective actions be monitored?*** The Regional Director and Administrator will check with the new manager at least on a weekly basis to see if there are any complaints or concerns. The New Manager of this facility has been instructed to call if she has any questions at all in regard to what may or may not be an abusive situation. The facility Administrator/Managers will have abuse in-services at least twice per year. ***Completion Date:*** In-service 10-24-07 and 11-14-07 and 11/30/07 On-going	

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November 16, 2007

Kathi Brink, Administrator
Ashley Manor Care Centers Inc - Orchard
PO Box 1176
Meridian, ID 83642

Dear Ms. Brink:

On October 18, 2007, a complaint investigation survey was conducted at Ashley Manor Care Centers Inc - Orchard. The survey was conducted by Rachel Corey, RN and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00003234

Allegation #1: An identified resident was physically and/or mentally abused by the house manager.

Findings: Based on observation and interview, it could not be determined that an identified resident was physically and or/mentally abused by the house manager.

Between October 16, 2007 and October 17, 2007, eight interviews took place with caregivers, the house manager, administrator and regional director. One caregiver alleged that physical and mental abuse occurred between the house manager and an indentified resident. However, there were no other witnesses to confirm this.

On October 19, 2007 at 8:30 a.m., Adult Protection called to reveal that their investigation resulted in an Unsubstantiated case.

On October 16, 2007 between 5:00 a.m. and 1:30 p.m., observations were made between the house manager and the identified resident. The indentified resident was observed following the house manager around with no evidence of fear.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #2: An allegation of abuse was reported to the regional manager and the facility's policies and procedures were not followed to protect the resident after an allegation of abuse was made known.

Findings: Based on interview, it was determined that the Regional Manager failed to follow policies and procedures to assure residents were free from abuse after an allegation of abuse was reported to her.

On October 17, 2007 at 3:31 p.m., the Regional Manager acknowledged that she had received a report of abuse. She confirmed that she did not report the allegation to Adult Protection, did not conduct an investigation nor ensure the resident was protected until a thorough investigation was completed.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for not assuring policies and procedures were implemented to protect residents from abuse. The facility was required to submit a plan of correction.

Allegation #3: On the evening of October 8, 2007, an untrained staff member was providing care to residents without the appropriate orientation to provide cares to the resident.

Findings: Based on record review and interviews, it could not be determined the indentified staff member provided cares to residents without proper training and orientation.

On October 16, 2007 the identified employee's record documented that 16 hours of orientation was completed by October 8, 2007. The as worked schedule for October 8, 2007 documented that the employee had worked with the house manager during orientation. Further review of the as worked schedule, found no dates where the employee had worked alone.

On October 16, 2007 at 9:40 a.m., the House Manager stated the indentified staff member had worked one day at the facility with him providing the training and orientation. He further stated the employee was not finished with orientation and would not be working indepently until training was complete.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation.

Allegation #4: The facility did not protect residents' rights for a safe and secure environment, as staff members argued in front of the residents during dinnertime.

Findings: Based on interview, it could not be determined staff did not respect residents' rights for a safe and secure environment by arguing in front to residents during dinnertime.

On October 16, 2007 at 6:45 a.m., the Administrator and Regional manager stated an argument between the house manager and caregivers occurred on October 8, 2007, but was promptly moved from the dining room to the office.

On October 17, 2007 at 11:00 a.m., a caregiver confirmed an argument between the house manager and caregivers was moved away from residents after the administrator intervened.

On October 17, 2007 at at 1:20 p.m., another caregiver stated the argument did not happen in front of residents, as most residents were in the living room at the time.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #5: An identified resident was not assisted with a prescribed nutritional supplement as ordered by the physician.

Findings: Based on record review, observation and interview, it was determined that an identified resident was not assisted with a prescribed nutritional supplement as ordered by the physician.

Review of the October Medication Record on October 16, 2007, documented that the resident did not receive 8 out of 30 scheduled doses of the nutritional supplement.

On October 16, 2007 at 8:20 a.m., the house manager was observed assisting the identified resident with an alternative nutritional drink, not prescribed by the physician. At this time, the house manager stated the family had brought the drink in as a replacement. He confirmed he did not have an order for the substitution. He also acknowledged the resident had missed some doses of the nutritional supplement due to not having the drink available.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.02 for not assuring medications correlated with physician orders. The facility was required to submit evidence of resolution within 30 days.

Allegation #6: An identifed resident fell between October 5, 2007 and October 6, 2007 and caregivers did not fill out an incident report.

Findings #6: Based on interview and record review, it could not be determined caregivers did not fill out an incident report after an identifed resident fell.

On October 16, 2007 after reviewing incident reports, nursing assessments and progress notes, it could not be determined that a fall occurred to the identified resident or the resident had sustained any injuries.

Between October 16, 2007 and October 17, 2007 during interviews, the administrator, Regional Director, House Manager and two caregivers denied having knowledge of an unreported fall occuring with the identified resident.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RACHEL COREY, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RC/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Rachel Corey, RN, Health Facility Surveyor